

EXHIBIT AA

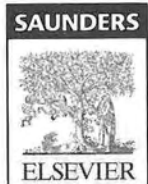
Manual of Surgical Pathology

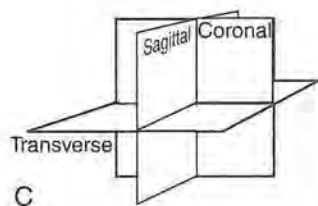
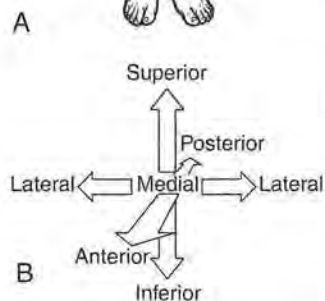
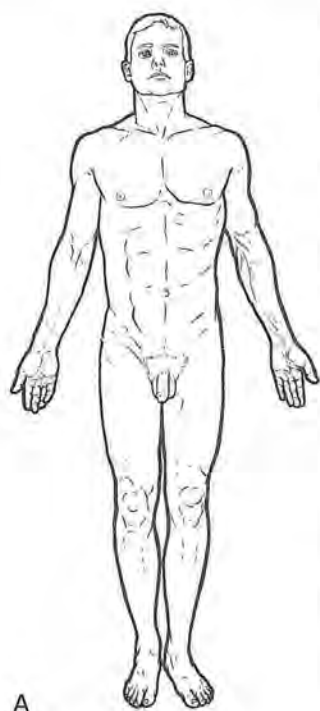
Third Edition



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**The (almost) anatomic position**

Person erect with head, eyes, and toes directed forward

Arms to the side with palms forward

Legs straight and feet together

Penis erect

All designations refer to the patient in the **anatomic position**. The actual position of the patient at the time of removing the specimen is irrelevant (e.g., supine, prone, sitting). Thus, superior is always cephalad, inferior caudad, etc.

Terms for orientation

Anterior (ventral): towards the front of the body. The volar surface refers to the palm of the hand (also "palmar") or the sole of the foot.

Posterior (dorsal): towards the back of the body. The upper surface of the foot is termed the dorsal surface because this is the position of the foot during embryonic development. The penis is in an erect position (the upper surface of the penis is the dorsal surface) for unknown reasons.

Superior (cephalic, cephalad): towards the head

Inferior (caudal, caudad): towards the feet. The inferior surface of the foot is termed the plantar surface.

Medial: median (midline) plane of the body

Lateral: away from the median plane of the body

Proximal: nearest the trunk or point of origin

Distal: farthest from the trunk or point of origin

Superficial: nearest to the skin surface

Deep: farthest from the skin surface

Transverse section: a horizontal plane at right angles to the longitudinal axis of the body or a body part with division into superior and inferior parts

Coronal section: a vertical plane that divides the body or body structure into anterior and posterior parts

Sagittal section: a vertical plane parallel to the median plane that divides the body or body structure into medial and lateral parts (= parasagittal)

Figure 1-2. The (almost) anatomic position.

ORIENTING PATHOLOGY SPECIMENS

The orientation of some specimens is evident from anatomical landmarks (e.g., a right colectomy). However, many specimens are either difficult or impossible to orient once the specimen has been removed from the patient (Figs. 1-1 and 1-2).

If orientation is important for the evaluation of a specimen (e.g., excisions of malignant tumors), and orientation has not been provided or is unclear, the pathologist should contact the surgeon before processing the specimen. It

is always preferable for the surgeon to personally discuss complicated specimens with the pathologist.

For most specimens, external markers must be used to provide information about orientation for the pathologist. The pathologist can then identify the site of the sections taken and relate them to the anatomic location in the patient. Possible techniques include:

- Sutures of variable composition, length, or number to mark anatomical sites (e.g., "deep margin") or areas of greatest concern (e.g., "closest margin"): Two sutures